September 8, 2021

Chiquita Brooks-LaSure, MPP, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1751–P
P.O. Box 8016
Baltimore, MD 21244-8016

Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Attention: CMS-1751-P

Submitted electronically to http://www.regulations.gov

Dear Administrator Brooks-LaSure:

The Sequoia Project is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) on interoperability-related provisions in the annual Medicare physician fee schedule proposed rule, primarily for the Medicare Merit-based Incentive Payment System (MIPS) Program. We appreciate CMS's demonstrated record of responding thoughtfully to the comments that it receives on such proposed rules from its many stakeholders.

The Sequoia Project is a non-profit, 501(c)(3) public-private collaborative that advances the interoperability of electronic health information for the public good. The Sequoia Project previously served as a corporate home for several independently governed health IT interoperability initiatives. The Sequoia Project currently supports the RSNA Image Share Validation Program and the Interoperability Matters Cooperative. We are also honored to have been selected by the Office of the National Coordinator for Health IT (ONC) to be the Recognized Coordinating Entity (RCE) for the Trusted Exchange Framework and Common Agreement (TEFCA).

These comments reflect our experience supporting large-scale, nationwide health information sharing, including active work with several federal government agencies. Through these efforts, we serve as an experienced, transparent, and neutral convener of public and private sector stakeholders to address and resolve practical challenges to interoperability. Our deep experience implementing national-level health IT interoperability, including our track record of supporting and operationalizing federal government and private sector interoperability initiatives, provide a unique perspective on the proposed rule.

Overview

The Sequoia Project supports CMS's focus on interoperability and patient access to data and its efforts to give providers greater flexibility while reducing their burdens. We also appreciate, as indicated below, proposals aimed at enhancing interoperability and information exchange. We provide suggestions based on our experience. In our comments, we highlight:

- Lessons learned and pertinent best practices from The Sequoia Project;
- The importance of a balanced approach to the various technologies and architectures available for provider-to-provider exchange; and
- The similar need for balancing the emphasis on making available, sending, receiving, and integrating data to enhance clinical care, outcomes, and patient experience.

Comments on Interoperability Measures for the Merit-based Incentive Payment System (MIPS) Program

- **PDMP—**CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure for CY 2022 and to maintain its current value of 10 bonus points.

  Comment: The Sequoia Project supports both aspects of this proposal for the reasons stated by CMS. Despite slower than desired progress in integration of PDMPs with EHRs, such integration, including the ability to query PDMPs, is very valuable and we believe that CMS strikes the appropriate balance in this proposal.

- **Proposed Changes to the Provide Patients Electronic Access to Their Health Information Measure Under the Provider to Patient Exchange Objective.** CMS is proposing to modify the *Provide Patients Electronic Access to Their Health Information* measure to require MIPS eligible clinicians to ensure that patient health information remains available to the patient (or patient-authorized representative) to access indefinitely and using any application of their choice that is configured to meet the certified technical specifications of the API in the eligible clinician's CEHRT. Eligible clinicians would be required to ensure this information remains available indefinitely, with the proposed requirement applying beginning with the EHR reporting period in CY 2022, and would include all patient health information from encounters on or after January 1, 2016. CMS asks for comment on the proposal and its specific features.

  Comment: The proposal reinforces the information blocking obligations established in ONC regulations but also creates some partial seeming inconsistency with the proposed CMS requirement to only ensure availability of data created on or after 1/1/2016 while the ONC information blocking regulations and associated FAQs state that all available EHI must be made available, including but not limited to that created on or after the 4/5/2021 "applicability date". We note that the CMS requirement focuses on having information available electronically. In contrast, under the information blocking regulations, a clinician that does not actually have electronic health information (EHI) for a period before 4/.5/2021 would not have obligations whereas the CMS proposed rule would seem to require actual

availability of such information as EHI. We ask CMS to work with ONC to ensure that CMS and ONC requirements regarding availability of electronic patient information are consistent and fully explained to providers and others.

- **Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT**—CMS proposes to revise "Information Blocking" attestations established in response to MACRA. In doing so, it notes that, per the 21st Century Cures legislation, "[a]ppropriate disincentives for health care providers need to be established by the Secretary through rulemaking." Substantively, CMS proposes to eliminate two of the current attestations as duplicative of and not fully consistent with the Cures information blocking provisions for providers.

  Comment: We agree with this proposed change as it will increase clarity on compliance obligations and enforcement and reduce the prospect of duplicative or conflicting enforcement. We urge that HHS proceed with appropriate speed, taking into careful consideration current pressures created by the COVID-19 pandemic, to propose for public comment the "additional disincentives" for providers so that the community has greater clarity on what will be expected and required and when.

Conclusions

We thank CMS for providing the opportunity to comment on this proposed rule. Again, we strongly support CMS's intention to focus its incentive programs on interoperability and urge CMS to deepen its proposed balanced emphasis on patient access to their data and provider–to-provider exchange, with the latter also facilitating and encouraging provider and other authorized queries of patient information using appropriate standards and trust frameworks.

The Sequoia Project is eager to assist CMS in advancing our national interoperability agenda.

Most respectfully,

Mariann Yeager

Mariann Yeager
CEO, The Sequoia Project